



**WESLEY**  
Medical Center

Scheduling: 962-7900

Fax To: 962-7637

Last Name:		First Name:		MI:
Birthdate:		SS #:		
Phone Number (Home):		(Work):		
Appointment Time:	Appointment Date:	Check in time in Admissions:		

## PHYSICIAN ORDER FOR NUCLEAR MEDICINE IMAGING

DIAGNOSIS/SYMPTOMS		CONTACT NUMBER FOR CRITICAL RESULT	FORM COMPLETED BY (PRINT NAME)	
			<input type="checkbox"/> <i>Page when results are available</i>	Fax results to:
DATE/TIME	ORDERING PHYSICIAN'S NAME	ICD-9 Code	<b>Order may be modified at the discretion of the Radiologist.</b>	
	PHYSICIAN'S SIGNATURE		<input type="checkbox"/> Please notify physician if order is modified.	

*Note: Please circle exam.*

Thyroid uptake	Thyroid uptake/scan	Whole body bone scan	Limited area bone	Diuretic Renal scan	Lung scan	Hepatobiliary scan
Myocardial Perfusion		RVG (MUGA)		RVG (MUGA)		
Treadmill	Pharmacological	Stress		Resting		
Cisternogram		Sentinal node injection		Before Chemo	During Chemo	After Chemo

**NUCLEAR MEDICINE**

Pertinent Medical History:	Patient's weight:

Other: